		I AND HUMAN SERVICES				-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F	000			
	Annual Licensure	and Certification Survey.					
F 221 SS=D	An extended surver 483.13(a) RIGHT T PHYSICAL RESTR	O BE FREE FROM	F	221			9/20/11
	physical restraints i discipline or conver	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.					
	by: Based on observat review the facility fa symptoms to justify waist restraint, did no restraint use, did no restraint Care Plan restraint reductions sampled with restra	NT is not met as evidenced tion, interview, and record ailed to identify medical the use of a self-releasing not provide alternatives to obt follow the individualized , and failed to implement , for one of four residents aints, (R7), in a sample of 21. cility failed to follow their and Procedures.					
	Findings include:						
	Procedure is, "Polic to utilize restraints of the resident's medi- use the least restric that medical sympto- discipline or conver following steps must	Restraint Use Policy and cy: It is the policy of the facility only when necessary to treat cal symptoms. The facility will ctive device necessary to treat om and not for the purpose of nience. Procedure: The st be completed prior to and d use of a restraint. 1.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 02/22/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTER STATEMENT AND PLAN C	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257	(X2) M A. BU B. WII	ILDIN NG STF	PLE CONSTRUCTION G REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE	FORM OMB NO. (X3) DATE SU COMPLE	
CRYSTA	L PINES REHAB & H			-	CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 221	indicating the media restraint. 3. Initiate plan to include: Ho medical symptom. in attaining or main practical well-being negative outcomes individual resident. use of an alternative device. Referrals to use of the least res minimize or elimina address any underl medical symptom. the continued need may not use restrai regulation solely ba representative's red R7's Admission Nur "(R7) has a, (Brand restraint), in place of making skills." The 3-3-2011 Quar MDS, (Minimum Da that R7 is assessed memory deficits, is decision making an symptoms. R7 is a dependent on staff daily living. These contain documenta falls since re-admis 5-1-2005.	ge 1 training assessment, cal symptoms requiring the e an appropriate treatment w the use would treat the How it will assist the resident taining his/her highest . Addressing the potential for , which might be specific to the A plan for reduction to the e, and/or less restrictive o assist in the reduction and trictive device. 4. Attempt to te the medical symptom, to ying problems causing the 5. Ongoing assessment for of a restraint. The facility nts in violation of the sed on a legal surrogate or quest, demand, or approval." rsing Note of 7-10-2000 is, Name self-releasing waist due to impaired decision terly and 5-25-2011 Annual ata Set) contain documentation d to have short and long term severely impaired in daily id does not exhibit behavioral lso assessed to be totally members for all activities of same MDS assessments tion that R7 has not had any ision to the facility on	F	221			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		145257	B. WI	NG _		08/2;	3/2011
NAME OF P	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & HO	cc			CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	restraint) on while (safety." The 5-30-2011 Indir contains the followin use: Full siderails f (A self-releasing was safety awareness, p Interventions identif for restrictions even On 8-15-2011 from her wheelchair with	re, "(A self-releasing waist R7's) up in wheelchair for vidualized Care Plan, for R7, ng documentation, "Restraint or safety per family request. aist restraint) due to lack of per family request." fied include, "Check restraint	F	221	1		
	 7-1-2010 through 3: documentation that contractures. The 7-3-2010 throu for Predicting Press documentation that ulcers. Quarterly Resident 7-3-2010 through 5: "Moderate Risk" for Safety Device Docu 	Are Assessments from -2-2011 contain R7 is "High Risk" for gh 8-18-2011 Quarterly Scale sure Sore Risk contain R7 is "High Risk" for pressure Fall Risk Assessments of -25-2011 document R7 is					
	self-releasing waist 2, for safety, due to understand her limi for all activities of d	restraint) and siderails, up x low cognition and inability to tations(R7) is dependant ally living, incontinent of bowel evere cognitive impairment.					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	√G		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC		_	35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 221	 (R7) is unable to fo self-release. (Z3, F Attorney), has discu- safety and wishes (safety and wishes (self-releasing waist this time. The facili (Z3), and are suppo (R7's) safety. 3-25- not feel a reduction due to her medical accident, alzheimer The 2-28-2011, 4-1 Physical Restraint E contain documenta Symptoms Necessi impaired cognition. 4-18-2011 Reduction bed." A 5-25-2011 restraint intervention Alternatives for com reduction documenta 2-28-2011, 4-18-200 toileting, activities, a On 8-15-2011 at 11 and 8-16-2011 at 11 and 8-16-2011 at 11:47 release the lap rest so. E5, (ADON/Assista 8-16-2011 at 11:47 release the (A self- are releasing (R7's and at lunch, for rest 	Illow commands and cannot Family Member/Power of ussed her concerns for (R7's) (R7) to have both, (A restraint), and siderails x2, at ity has discussed this with ortive of her wishes to maintain -2010, at this time (Z3) does would be beneficial to her, conditions, cerebral vascular r's disease, and dementia." 8-2011, and 5-25-2011 Elimination Assessments tion that R7's "Medical itating Use of Restraint: " The 2-28-2011 and on or Elimination are, "while in Reduction or Elimination of ons/plan, etc. are not identified. of the for 011, and 5-25-2011 are and call light prompts. 1:05am., 8-15-2011 at 1:30pm. :20am. R7 was unable to traint, after being asked to do ant Director of Nursing) on am. stated, "(R7) cannot -releasing waist restraint). We) lap restraint every two hours duction of restraint. I will we are doing to reduce (R7's)	F	221			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG		08/2;	3/2011
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & HO	CC			CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 221	Continued From pa	ge 4	F	221	1		
F 224 SS=H	Nursing) stated, "Th restraint reduction f adamant about the with the restraint, an pro-family and resic contacted the docto up every year." 483.13(c) PROHIBI MISTREATMENT/N N The facility must de policies and proced mistreatment, negle	NEGLECT/MISAPPROPRIAT	F	224	4		9/20/11
	by: Based on interview failed/neglected to f facility's policy and Prevention" in the fr 1. Assessment; - A risk assessment (B identify residents w development of pre assessment will be weekly x 4 weeks, of significant change i noted. 2. Planning: - An in be developed to me It will include the co	A standardized pressure ulcer raden Scale) will be used to ho are at risk for the					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WIN	G		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	сс			35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	 mobility, continence clinical condition of factors as they app 3. Implementation: prevention of pressindividualized to me resident. Interventia assessment of risk resident. 4. Evaluation and R Care Management program componer effectiveness of the facility systems. Fi will be reviewed wite Based on evaluation and further change plan of care will be This is for 5 (R4, R residents sampled sample of 21 with 3 R26) in the suppler These failures containd worsening of a pressure sores in v residents. Findings include; A review of the faci Conditions of Residents with pression residents had pression 	e, skin condition and overall the resident as well as the risk ly to each individual. - Interventions for the sure ulcers will be eet the specific needs of the ions will consider the and skin condition of the Reassessment: - The facility's System committee will review hts to evaluate the e prevention program and ndings and recommendations th the QA Clinical Committee. on, the need for reassessment s to the individual resident' determined and acted upon. 5, R6, R8, R14) of the 7 for pressure sores in a total B residents (R24, R25 and	F 2	24			

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CENTER		AND HUMAN SERVICES		<u></u>	TIPLE CONSTRUCTION	FORM	02/22/2012 APPROVED 0938-0391
	DF CORRECTION	IDENTIFICATION NUMBER:	(A2) N			COMPLE	
		145257	B. WI	NG _		08/23	3/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & HO	CC			CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	administrator and E stated that they are regarding pressure facility. E1 stated the reasons why this of 2011 the facility cer and that the facility the needs of their re- stated that after loo believe that staffing the facility experien utilized the back-up primary goal during making sure the res stated that perhaps overlooked at this the In an interview on 8 medical director, he the facilities acquire quarterly quality ass that he was probab numbers of acquire not recall how many that he believes in the pressure sore preve- checks, frequent re care. Z1 states that vigilant in these pre- that there was a bre but he cannot say vo occurred. Z1 states	E2, the director of nursing, they aware of the problem sores recently acquired in the hat they are looking at the ccurred. E1 stated that in July nsus went from 90 to over 100 had to hire more staff to meet esidents. E1 stated that the as it should be regarding ention because they did not On 8/17/11 at 10:15 AM E1 oking at the staffing, they now g was sufficient. E1 stated that iced power outages that o generator. E1 stated that the these power outages was sidents were hydrated. E1 is some preventive care was	F	224			

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	IG		08/2	3/2011
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	Continued From pa	ige 7	F:	224			
	for her dressing cha nurse, removed R5 wound is a Stage 3 centimeter (cm) by pressure sore has a approximately 25% confirms a worsenin The record of R5, a to the facility on 8/1 morbidities) includin Disease, Hypertens R5 ' s record contai order dated 7/18/1 coccyx with sterile in AG and a 4 by 4 Ex needed until resolve " Braden " pressure that states she scol mild risk " The min states that she nee transfer, assistance uses a wheelchair incontinent of bowe Pressure Ulcer Ass 7/18/11 that states coccyx pressure so measured .52 cm b Pressure Ulcer Ass that the wound is no depth which is a wo R5's "Weekly Press dated 8/2/11 states stage 3 measuring	2:10 AM R5 was in bed waiting ange. E6, the wound care ''s coccyx dressing. R5 's pressure ulcer measuring 2.1 1.3cm by .2cm depth. The a thin center yellow slough . These measurements ng of the pressure sore. a 78 year old female admitted 5/09 with diagnoses (co ng Diabetes, Coronary Artery sion and Anxiety was reviewed. ins a physician 's treatment 1 that states. " Cleanse normal saline apply Maxorb cuderm every 3 days and as ed." R5 's record contains a e sore scale dated 6/13/11 red a 15 which is considered " nimum data set dated 5/17/11 ds extensive assistance to e to position herself in bed, and for ambulation and is el and bladder. R5's "Weekly sessment" sheet dated this is the date that a stage 2 ore was identified and by .51cm. R5's "Weekly sessment" dated 7/26/11 states ow 1.5cm by 1.5cm by .1 orsening of the pressure sore. Sure Ulcer Assessment" sheet that her pressure sore is a 1.5cm by .8cm by .2cm with a, this is a significant essure sore.					

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2;	3/2011
NAME OF F	ROVIDER OR SUPPLIER	l			REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	сс			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	 sheets show a decl pressure sore every sheet do not show the onset of the pre R5's record lacks a to prevent and treat In an interview with she states that som care clinic and som physician's are ope and some are not. remember which re will use a wound cli aware that the wou previously. 2. On 8/16/11 at 10 waiting for her heel has an unstageable measuring 4.0cm b periphery of the wo eschar center (75% This is a worsening injury" that was door The record of R14, admitted to the faci (co morbilities) incli Hypertension, Wea was reviewed. R14 Scale for Predicting 7/11/11 that states risk" on this scale. "Weekly Pressure I 	sure Ulcer Assessment" line or worsening in the y week. The physician's order a change in treatment since essure sore on 7/18/11. comprehensive plan of care	F	224			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2;	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	depth is stated as " a physician's order states "Cleanse left saline. Apply skin p optifoam and wrap contains a Minimum 6/20/11 that states bed mobility, transfe R14's MDS states t ambulation and she bladder. In an interview with stated that she doe developed her pres assessments states developed her pres assessments states development of pre 3. On 8/16/11 at 10 admitted to the hos pressure sores. E2 presented a history hospital regarding F is here from the nun complaint of right for drainageFamily a had decubitus ulcer increased wound ca month2 unstagea right foot, foul smel present. Also deep right knee and decu consulting surgery for care"	asured 5.2cm by 5.9cm and blister". R14's record contains for treatment dated 8/8/11 that t medial heel with normal orep to intact blister, cover with with kerlix." R14's record n Data Set (MDS) dated she needs assistance with ers dressing and hygrine. that she uses a wheelchair for e continent of bowel and E6,the wound care nurse, she is not know how this resident issure sore and that her s she was at low risk for	F	224			

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG		08/2;	3/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	Dementia, Anxiety I disease was review states that she required bed, transferring, di MDS also states that of both bowel and b wheelchair for amb a "Braden scale for dated 7/6/11 that st signifies "high risk" record contains "W Assessment" dated is when a stage 3 r identified and meas with 60% necrotic ti "Weekly Pressure U 8/6/11 that states a pressure ulcer was by .2cm depth. R4 Pressure Ulcer " da medial knee pressu 75% necrotic tissue 4. On 8/16/11 at 1 waiting for her dress the right buttock wo depth and a Stage was bleeding slight E6 stated that she of developed this press The record of R25 at to he facility with dia including Urinary In Hypertension was r contains a "Braden Sores" that state sh	Hypertension and Joint wed. R4's MDS dated 5/26/11 uires assistance with turning in ressing and bathing. R4's at she is frequently incontinent bladder and that she uses a ulation. E4's record contains predicting pressure sore risk" tates a score of 10 that for pressure sores. R4's eekly Pressure Ulcer d 6/16/11 that states this date right hip pressure ulcer was sured 3cm by 1.8cm by .2cm issue. R4's record contains a Ulcer Assessment" dated a stage 2 left medial knee noted measuring 3cm by 2cm 's record contains a "Weekly ated 8/9/11 that states the left ure sore is now a stage 3 with e. 1:00 AM R25 was in bed asing change. E6 measured bund at .3cm by .2cm by .1 cm 2 pressure ulcer. The wound ly. does not know why R25	F	224			

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CENTEI STATEMEN	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) N	/ULT	TIPLE CONSTRUCTION	FORM OMB NO. (X3) DATE SI		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDI	ING	COMPLE	TED	
		145257	B. WI	NG _		08/23/2011		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
CRYSTA	L PINES REHAB & H	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 224	contains a "Weekly Assessment" dated acquired a left buttor measuring .5cm by record contains an she required extens toilet and some ass dressing. This MDS wheelchair for amb incontinent of uri ne of bowel. 5. On 8/16/11 at 10 for her dressing cha hip Stage 2 pressur her thoracic spine S by .7cm by .1 cm da not know why this r pressure sores. The record of R6 a tot he facility with di including Congesti Cerebral Vascular A Weakness was rev "Weekly Pressure U 6/4/11 that states s Stage 2 pressure so by .1cm. R6's reco Pressure Ulcer Ass states she acquired measuring 1.3cm b an MDS dated 6/5/ extensive assistance hygiene. This MDS incontinent of bowe	 Pressure Ulcer 8/2/11 that states she ocks stage 2 pressure ulcer .8cm by .1 cm depth. R25's MDS dated 7/21/11 that states sive assistance to transfer and istance for bed mobility and 5 states R25 used a ulation and that she is e and occasionally incontinent 0:30 AM R6 was in bed waiting ange. E6 measured her right re sore as .5cm by .5cm and 5tage 2 pressure sore as .8cm epth. E6 states that she does esident developed her 93 year old female admitted agnoses(co morbidities) ve Heart Failure, Late Effect Accident and Muscle iewed. R6's record contains a Jlcer Assessment" dated he acquired a thoracic spine ore measuring .3cm by .3cm rd contains a "Weekly essment" dated/12/11 that I a right hip pressure sore y .2cm. R6's record contains 11 that states she required e with transfers, dressing and a also states that she is 	F	224	4			

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		145257	B. WI	NG _		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	AL PINES REHAB & HO	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	waiting for her dress her left buttock Stag .5cm by .1 cm dept slightly. E6 stated to R24 developed a pr The record of R24 a admitted to the facil morbidities) includir Fibrillation, Ischemi Dementia was revie "Braden Scale for F dated 8/5/11 that so considered "Mild Ri "Weekly Pressure U 8/5/11 that states h pressure ulcer mea cm depth. R24;s re 7/5/11 that states st assistance to transf MDS also states tha with bed mobility, ea is frequently inconti incontinent of bowe 7. On 8/16/11 E6 st another dressing ch purposes. On 8/18/ stated that R26 was hospital due to resp The record of R26 a admitted to the facil Diabetes (co morbid record contains a "E Pressure Sore Risk 15 which is conside	sing change. E6 measured ge 2 pressure sore 1cm by th. This wound was bleeding that she does not know why ressure ulcer. an 88 year old female lity with diagnoses (co ng Dysphagia, Atrial ic Heart Disease and ewed. R24's record contains a Predicting Pressure Sore Risk" cores her a 15 which is isk". R24's record contains a Ulcer Assessment" dated ter right inner buttock Stage 2 asured 1.6cm by .6cm by .001 ecord contains a MDS dated he requires extensive fer and for dressing. This at R24 requires assistance ating and hygiene and that she inent of urine and occasionally el. tated that R26 refused to have hange for observation '11 E1, the administrator s being admitted to the	F	224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IL6002299

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/23	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & HO	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	dated 8/6/11 that st inner buttock press cm by .01 cm depth MDS dated 8/10/11 extensive assistance hygiene. This MDS assistance with bec states that R26 is in bladder. 8. On 8/16/2011 at condition was chec (CNA-certified nurs pressure ulcer on h Review of record "N dated 8/8/2011 sho measures 1.5 x 3x record,this pressure was acquired by R8 Review of current c was identified with a related to declining bladder and bowel, vascular accident), sensation in feet. T interventions to adc includes for R8 to b redistributing mattre cushion. R8 was observed o A.M., 8/16/2011 at R8 was sitting in a observation showed on the reclining whe	age 13 tates she developed a right ure sore measuring .8cm by 1 h. R26's record contains an that states she requires ce for transfers, dressing and 3 also states that she requires d mobility. This MDS also noontinent of bowel and t at 11:45 A.M., R8's skin ked in the presence of E10 te assistant). R8 has a stage II ter right upper spine. Monthly Skin Assessment" wed that R8's pressure ulcer 0.1 cm. According to R8's e ulcer was first identified and 3 at the facility on 8/8/2011. tare plan indicated that R8 at risk for pressure ulcers condition, incontinence of history of CVA(cerebral right sided weakness and loss he care plan indicates that dress R8's pressure ulcer be placed on a pressure ess in bed and wheelchair on 8/15/2011 at around 10:30 12:30 P.M., and 2:30 P.M. reclining wheelchair. Further d that R8 was sitting directly eelchair without a pressure cushion. On 8/16/2011 at 2:30	F	224			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2	3/2011
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & HO	00			CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224 F 314 SS=H	P.M., E13 (CNA) sta R8 's reclining whee On 8/16/2011 at 3:1 meeting, the concer- redistribution cushic was discussed with (Director of Nursing) On 8/17/2011 at 12 the main dining roor reclining chair. R8 v redistribution cushic Nursing) was prese All of the document was reviewed. 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat review the facility fa 1. Implement a pre	ated that she never had seen elchair cushion. 10 P.M. during the daily status rn that R8 was without on in a reclining wheelchair E1 (Administrator) and E2 g). :30 P.M., R8 was observed in m. R8 was sitting on a was still without a pressure on. E5 (Assistant Director of ent during this observation. :ation presented by the facility IENT/SVCS TO RESSURE SORES orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced tion, interview and record		314			9/20/11

		I AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG		08/2;	3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	with Un-stageable p with Stage 3 press Stage 2 pressure so pressure sore), and 2. Provide the neod promote healing, and sores from worsenin R4). This is for 5 of the 3 pressure sores in a residents in the sup These failures cont and worsening of a various stages for t Findings include; 1. On 8/16/11 at 10 waiting for her dress care nurse, remove 's wound is a Stage 2.1 centimeter (cm) The pressure sore approximately 25% indicate a worsenin The record of R5 m admitted to the faci morbidities) includin Disease, Hypertens contains a physicia 7/18/11 that states. normal saline apply Exuderm every 3 da resolved. " R5's ref	eight residents R4 and R14 pressure sores, R5, R6 and R8 ure sores, R24 and R25 with ores and R26 with a stage 1 d essary care and services to nd prevent developed pressure ng for three residents (R5 and 7 residents sampled for total sample of 21 with 3	F	314			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145257	B. WI	NG _		08/2:	3/2011
NAME OF PROVIDER OR S	UPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL PINES REF	HAB & H	cc			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
PREFIX (EACH D	EFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
The minimus she needs assistance wheelchair bowel and Assessmen Stage 2 comeasured Pressure U that the wo depth whick R5's "Weel dated 8/2/1 stage 3 me 50% necroi worsening R5's "Weel sheets sho pressure so sheets do n the onset of R5's record to prevent a In an intervishe states care clinic a physician's and some a remember will use a w aware that previously.	a 15 wh um data extensiv to positi for amb bladder. nt" sheet ccyx pre .52 cm b Jlcer Ass bund is n h is a wo kly Press asturing tic tissue of the pre tic tissue of the pre d lacks a and trea view with that som are ope are not. which re vound cli the wou	age 16 hich is considered " mild risk " set dated 5/17/11 states that re assistance to transfer, on herself in bed, and uses a ulation and is incontinent of R5's "Weekly Pressure Ulcer t dated 7/18/11 noted that a assure sore was identified and by .51cm. R5's "Weekly bessment" dated 7/26/11 states ow 1.5cm by 1.5cm by .1 orsening of the pressure sore. Sure Ulcer Assessment" sheet t that her pressure sore is a 1.5cm by .8cm by .2cm with a, this is a significant ressure sore. Sure Ulcer Assessment" ine or worsening in the y week. The physician's order y a change in treatment since essure sore on 7/18/11. Comprehensive plan of care t pressure ulcers. E6, the wound care nurse, ne physician's utilize a wound the do not. E6 stated that some in to treatment suggestions E6 stated she does not esidents have physician's that inic. E6 stated that she is nd is worse than it was D:20 AM R14 was in bed dressing to be changed. R14 e pressure ulcer to her left heel	F	314	4		

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145257	B. WI	NG _		08/2:	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & HO	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	measuring 4.0cm b periphery of the wo eschar center (75% This is a worsening injury" that was doo The record of R14,; admitted to the faci morbilities) includin Hypertension, Wea was reviewed. R14 Scale for Predicting 7/11/11 that states risk" on this scale. "Weekly Pressure II 8/5/11 that states a was found and mea depth is stated as " a physician's order states "Cleanse left saline. Apply skin p optifoam and wrap contains a Minimun 6/20/11 that states bed mobility, transfe R14's MDS states t ambulation and she bladder. In an interview with stated that she doe developed her pres assessments state development of pre 3. On 8/16/11 at 10 admitted to the hos pressure sores. E2 presented a history	y 5.0 cm by .1 cm at the und. R14's wound has a black b) with surrounding red tissue. of the "suspected deep tissue cumented on 8/9/11. an 87 year old female lity with diagnoses (co g Pelvic Fracture, kness and Difficulty in walking, I's record contains a "Braden g Pressure Sore Risk" dated she scored a 22 which is "mild R14's record contains a Jlcer Assessment' dated suspected deep tissue injury asured 5.2cm by 5.9cm and blister". R14's record contains for treatment dated 8/8/11 that t medial heel with normal orep to intact blister, cover with with kerlix." R14's record n Data Set (MDS) dated she needs assistance with ers dressing and hygrine. that she uses a wheelchair for e continent of bowel and E6,the wound care nurse, she s not know how this resident sure sore and that her she was at low risk for	F	314			

Facility ID: IL6002299

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG		08/2:	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	AL PINES REHAB & H	CC			35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	is here from the nu complaint of right for drainageFamily a had decubitus ulcer increased wound ca month2 unstagea right foot, foul smel present. Also deep right knee and decu consulting surgery care" The record of R4 a to the facility with o including Diabetes, Hypertension and J R4's MDS dated 5/3 assistance with turr dressing and bathir she is frequently into bladder and that sh ambulation. E4's re for predicting press that states a score for pressure sores. Pressure Ulcer Assistates this date is op pressure ulcer was by 1.8cm by .2cm v record contains a " Assessment" dated by 2cm by .2cm de "Weekly Pressure U the left medial knee 3 with 75% necrotio 4. On 8/16/11 at 1	rsing home with chief bot pain and right foot also noted that the patient also rs for some time but noted are needs for the past able ulcers on the patient's lling with necrotic tissue to tissue injury in the medial ubitus on the right hipWill be for wound debridement and n 84 year old female admitted diagnoses (co morbidity) Dementia, Anxiety, Joint disease was reviewed. 26/11 states that she requires hing in bed, transferring, ng. R4's MDS also states that continent of both bowel and the uses a wheelchair for ecord contains a "Braden scale sure sore risk" dated 7/6/11 of 10 that signifies "high risk" R4's record contains "Weekly sessment" dated 6/16/11 that when a stage 3 right hip identified and measured 3cm with 60% necrotic tissue. R4's Weekly Pressure Ulcer 4 8/6/11 that states a Stage 2 essure ulcer measuring 3cm pth. R4's record contains a Ulcer " dated 8/9/11 that states e pressure sore is now a Stage	F	314			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145257 08/23/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE **CRYSTAL PINES REHAB & HCC** CRYSTAL LAKE, IL 60014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 19 F 314 the right buttock wound at .3cm by .2cm by .1 cm depth and a Stage 2 pressure ulcer. The wound was bleeding slightly. E6 stated that she does not know why R25 developed this pressure ulcer. The record of R25 a 94 year old female admitted to he facility with diagnoses (co morbidities) including Urinary Incontinence. Depression and Hypertension was reviewed. R25's record contains a "Braden Scale for Predicting Pressure Sores" that state she scored an 11 on 7/24/11 which is considered "High Risk" R25's record contains a "Weekly Pressure Ulcer Assessment" dated 8/2/11 that states she acquired a left buttocks stage 2 pressure ulcer measuring .5cm by .8cm by .1 cm depth. R25's record contains an MDS dated 7/21/11 that states she required extensive assistance to transfer and toilet and some assistance for bed mobility and dressing. This MDS states R25 used a wheelchair for ambulation and that she is incontinent of uri ne and occasionally incontinent of bowel. 5. On 8/16/11 at 10:30 AM R6 was in bed waiting for her dressing change. E6 measured her right hip Stage 2 pressure sore as .5cm by .5cm and her thoracic spine Stage 2 pressure sore as .8cm by .7cm by .1 cm depth. E6 states that she does not know why this resident developed her pressure sores. The record of R6 a 93 year old female admitted to the facility with diagnoses(co morbidities) including Congestive Heart Failure, Late Effect Cerebral Vascular Accident and Muscle Weakness was reviewed. R6's record contains a "Weekly Pressure Ulcer Assessment" dated 6/4/11 that states she acquired a thoracic spine

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145257	B. WI	NG _		08/23	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & HO	00			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	Stage 2 pressure so by .1cm. R6's reco Pressure Ulcer Ass states she acquired measuring 1.3cm b an MDS dated 6/5/ ² extensive assistance hygiene. This MDS incontinent of bowe 6. On 8/16/11 at 11 waiting for her dress her left buttock Stag .5cm by .1 cm dept slightly. E6 stated to R24 developed a pr The record of R24 a admitted to the facil morbidities) includir Fibrillation, Ischemi Dementia was revie "Braden Scale for F dated 8/5/11 that so considered "Mild Ri "Weekly Pressure U 8/5/11 that states h pressure ulcer mea cm depth. R24;s re 7/5/11 that states sh assistance to transf MDS also states that with bed mobility, ea is frequently inconti incontinent of bowe 7. On 8/16/11 E6 s another dressing ch	ore measuring .3cm by .3cm rd contains a "Weekly bessment" dated/12/11 that d a right hip pressure sore by .2cm. R6's record contains 11 that states she required be with transfers, dressing and a also states that she is el and bladder. 1:50 AM R24 was in bed sing change. E6 measured ge 2 pressure sore 1cm by h. This wound was bleeding that she does not know why ressure ulcer. an 88 year old female lity with diagnoses (co ng Dysphagia, Atrial ic Heart Disease and ewed. R24's record contains a Predicting Pressure Sore Risk" cores her a 15 which is isk". R24's record contains a Jlcer Assessment" dated er right inner buttock Stage 2 isured 1.6cm by .6cm by .001 ecord contains a MDS dated he requires extensive fer and for dressing. This at R24 requires assistance ating and hygiene and that she nent of urine and occasionally	F	314			

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		I AND HUMAN SERVICES			FORM	02/22/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WING		08/23	3/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & H	CC		CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	stated that R26 was hospital due to resp The record of R26 admitted to the faci Diabetes (co morbin record contains a "I Pressure Sore Risk 15 which is conside contains a "Weekly dated 8/6/11 that st inner buttock press cm by .01 cm depth MDS dated 8/10/11 extensive assistance hygiene. This MDS assistance with beo states that R26 is in bladder. 8. On 8/16/2011 a condition was chec (CNA-certified nurs pressure ulcer on h Review of record " dated 8/8/2011 sho measures 1.5 x 3x record,this pressure was acquired by R8 Review of current of was identified with a related to declining bladder and bowel, vascular accident), sensation in feet. T interventions to add includes for R8 to b	s being admitted to the	F 314	4		

Facility ID: IL6002299

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145257 08/23/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 335 NORTH ILLINOIS AVENUE **CRYSTAL PINES REHAB & HCC** CRYSTAL LAKE, IL 60014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 22 F 314 R8 was observed on 8/15/2011 at around 10:30 A.M., 8/16/2011 at 12:30 P.M., and 2:30 P.M. R8 was sitting in a reclining wheelchair. Further observation showed that R8's was sitting directly on the reclining wheelchair without an pressure redistribution chair cushion. On 8/16/2011 at 2:30 P.M., E13 (CNA) stated that she never had seen R8 's reclining wheelchair cushion. On 8/16/2011 at 3:10 P.M. during the daily status meeting, the concern that R8 was without redistribution cushion in a reclining wheelchair was discussed with E1 (Administrator) and E2 (Director of Nursing) during the daily status meeting. On 8/17/2011 at 12:30 P.M., R8 was observed in the main dining room. R8 was sitting on a reclining chair. R8 was still without a pressure redistribution cushion. E5 (Assistant Director of Nursing) was present during this observation. In an interview on 8/16/11 at 2:30 PM with E1, the administrator and E2, the director of nursing, they stated that they are aware of the problem regarding pressure sores recently acquired in the facility. E1 stated that they are looking at the reasons why this occurred. E1 stated that in July 2011 the facility census went from 90 to over 100 and that the facility had to hire more staff to meet the needs of their residents. E1 stated that the care was not given as it should be regarding pressure sore prevention because they did not have enough staff. On 8/17/11 at 10:15 AM E1 stated that after looking at the staffing, they now believe that staffing was sufficient. E1 stated that the facility experienced power outages that utilized the back-up generator. E1 stated that the primary goal during these power outages was making sure the residents were hydrated. E1

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 23	F	314			
	stated that perhaps overlooked at this t	some preventive care was ime.					
F 322 SS=D	medical director, he the facilities acquire quarterly quality ass that he was probab numbers of acquire not recall how many that he believes in the pressure sore prevent checks, frequent recare. Z1 states that vigilant in these prevents that there was a breat but he cannot say wo occurred. Z1 states recommending inter with the plan of rem jeopardy situation. 483.25(g)(2) NG TF RESTORE EATING Based on the comp resident, the facility who is fed by a nass receives the approp- to prevent aspiratio vomiting, dehydratic and nasal-pharynge possible, normal eat This REQUIREMEN	prehensive assessment of a must ensure that a resident o-gastric or gastrostomy tube priate treatment and services n pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers and to restore, if	F	322			9/20/11
		tion, interview, and record ailed to follow their Medication					

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		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	NG _		08/2;	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322	Administration /Nas and Jejunostomy T one of four resident tubes, in the sample Findings include: The undated Medic /Naso-Gastric Tube Jejunostomy Tubes provided 8-16-2011 (DON/Director of N will be provided for through an artificial via naso-gastric tub administering medic semi-Fowler positio Expose tube, place plug. Check patent of tube prior to adm Clamp the tube bef syringe. Rinse and E2, (DON) on 8-16- "Semi-fowler positio On 8-16-2011 at 8:3 head of the bed wa E3, (LPN/Licensed increase bed elevat did not place a basi	so-Gastric Tubes, Gastrostomy ubes Policy and Procedure for ts, (R1), with gastrostomy e of twenty-one. ation Administration es, Gastrostomy and s Policy and Procedure, I at 10:20am., by E2, ursing) is, "Policy: Medication residents requiring feeding opening into the stomach or be. Procedure for cation: 2. Assist resident to on unless contraindicated. 3. basin under tube, and remove cy of tube and for placement ninistering any solution. 7. fore it empties, and remove	F	322			
	medication adminis tube patency and p prior to administerir R1's 9:00am. medic of 5ml., (milliliters) of	stration. R1's gastrostomy lacement were not checked ng R1's 9:00am. medication. cation administration consisted of multivitamins, four crushed of water. E3, then clamped					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/22/2012

		I AND HUMAN SERVICES					APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		145257	B. WI	NG _		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322	Continued From pa the gastrostomy tub syringe.	ge 25 be and did not rinse the	F	322			
F 329	did not check place tube, prior to admin checked it, when I a rounds." 483.25(I) DRUG RE	2011 at 8:45am. stated, "No, I ment of (R1's) gastrostomy istering her medication. I arrived this morning, on EGIMEN IS FREE FROM	F	329			9/20/11
SS=D	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any					
		NT is not met as evidenced					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/22/2012

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145257	B. WII	NG _		08/23	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	by: Based on observat review the facility fa assessment to iden failed to try alternat insomnia, prior to ir hypnotic medication develop care plans and for an antipsyc resident (R13) out of psychotropic medic 21. The findings include R13 is an 88 year-or resident who was a 5/12/11 with diagno Disease and Psych admission Minimum 5/19/11. R13 has p Trazodone 50 mg e Ambien 10 mg even physician's order sh 2011. R13 received to current (8/17/11) 7/30, 7/31, 8/12 - 8 Medication Adminis was no documenta R13's insomnia and non-pharmacologic giving R13 Trazodo confirmed by E7 (N There is no care pla antipsychotic and h to review of the fact	tion, interview and record ailed to complete an ntify reasons for insomnia, and tive interventions to treat nitiating duplicate therapy ns. The facility also failed to for the hypnotic medications hotic medication. This is for 1 of 13 reviewed for cations in the total sample of	F	329			

Facility ID: IL6002299

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145257	B. WI	\G		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & HO	CC			35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From pa 8/18/11 at 11:00 AN	-	F	329			
	hypnotic or antipsyc	t have a policy for the use of chotic medications. This was 8/18/11 at 1:20 PM.					
F 368 SS=E	100 hallway at 10:3 8/18/11 R13 was as 10:47 AM and 11:1	is asleep in a wheelchair in the 0 AM and at 11:25 AM. On sleep in bed at 10:35 AM, 5 AM. NCY OF MEALS/SNACKS AT	F	368			9/20/11
	least three meals d	ives and the facility provides at aily, at regular times nal mealtimes in the					
	substantial evening	nore than 14 hours between a meal and breakfast the pt as provided below.					
	The facility must off	fer snacks at bedtime daily.					
	up to 16 hours may evening meal and b	snack is provided at bedtime, e elapse between a substantial preakfast the following day if a ses to this meal span, and a served.					
	by: Based on interview	NT is not met as evidenced the facility failed to ensure offered a bedtime snack.					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145257	B. WI	NG		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & H	CC		-	RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 368	Continued From pa	ige 28	F:	368			
	attending the group confirmed that the f	D AM five alert residents o meeting. All 5 residents facility does not offer snacks at dents said that they would like ck at bedtime.					
	Supervisor) stated t a cart for night time utility room. E12 sa	D AM E12 (Food Service that the kitchen staff prepares snacks and brings it to the aid that nursing staff are he snacks to residents.					
F 371 SS=F	will be provided dai nursing staff. 483.35(i) FOOD PF	states that H.S. (night) snack ly and will be passed by the ROCURE, /SERVE - SANITARY	F;	371			9/20/11
	considered satisfac authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions					
	by: Based on observat review the facility fa machine was clean clean dishes on a c that dishes and par	NT is not met as evidenced tion, interview and record ailed to ensure that the ice red regularly; failed to store clean surface; failed to ensure ns were clean prior to storing; nufacturers instructions for					

Facility ID: IL6002299

If continuation sheet Page 29 of 45

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145257	B. WI	√G _		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	cc			35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	sanitizing; failed to trained in testing fo failed to ensure that of the dish machine This failure has the residents residing a The findings include On 8/17/11 betwee observations were inside of the ice mat pink-orange substat spots. On 8/17/11 that the ice machin maintenance depar identified as clean f was soiled; addition bowls were soiled. of dry cereal were so crumbs. Five utens crumbs or crud, and with the soiled area with a dried substat Two rubber head s with missing chunk the clean had visibl cheese grater stored dried substance ad shallow soup bowls dried food stuff adh On 8/17/11 at 2:05 compartment sink r 114 degrees Fahre tub states that the t	ensure that staff were properly r sanitation concentration, and t the chemical concentration e was at the appropriate level. • potential to affect all 102 at the facility. e: n 1:30 - 2:00 PM the following made in the kitchen: The achine was soiled with a unce and a smattering of black at 12:21 PM, E9 (Cook) stated e is cleaned by the rtment. A bin of bowls, by E9, was in a plastic bin that hally the cloth covering the The lids covering 3 containers soiled with dried spills and sil drawers were soiled with d the utensils were in contact as. One scooper was noted nce adhered to the inside. patulas were in poor condition s of rubber. Pans stored in le grease on them. The ed in the clean area had a hered to the inside. Three s stored in the clean area had	F	371			

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145257	B. WIN	NG _		08/2	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & HO	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	Continued From pa aware of this requir	-	F	371			
F 441 SS=E	E11 (Dish Machine measure the sanita automatic dish mac ammonia (QT-40) s concentration. The not match the poss E11 tried 2 more tin The facility uses a li- chlorine-based cheid dishes in the dish m that he was using th the sanitation concer was then obtained a chlorine sanitizer m The facility's policy Dishmachine" dated sanitizing level show On 8/17/11 at 2:00 the kitchen and view concerns. 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c	Operator) was asked to tion concentration of the chine. E11 used a quaternary strip to measure the chemical e strip turned a color that did ible colors on the result ledger. mes and got the same result. ow temperature, mical solution to sanitize nachine. E11 was not aware he wrong test strip to measure entration. A chlorine test strip and the concentration of the leasured 200 ppm. titled, "Warewashing - d 07/07 states that the chlorine uld be 50 ppm. PM E1 (Administrator) toured wed the above described I CONTROL, PREVENT	F٠	441			9/20/11
	Program under whi	tablish an Infection Control					

Facility ID: IL6002299

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STATE MEENT OF DEFICIENCIES AND PLAND OF CORRECTION (M) Perportigication NUMBER: DEPENTION NUMBER: 145257 (M) NUMPER A BULDING 145257 (M) NUMPER A BULDING 14557 (M) NUMPER A B			I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER Image: Control of the	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '			(X3) DATE SU	JRVEY
CRYSTAL PINES REHAB & HCC 33 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 0014 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICENCY) 000000000000000000000000000000000000			145257	B. WI	NG _		08/23	3/2011
CRYSTAL PINES REHAR & A HCC CRYSTAL LAKE, IL 60014 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S ALL OR CORRECTION (EACH DEFICIENCY WIST BE RECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S ALL OR CORRECTION (EACH DEFICIENCY) OWN TO DEFICIENCY) F 441 Continued From page 31 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains are record of incidents and corrective actions related to infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of Infection, the facility must isolate the resident. F 441 (2) The facility must provine staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow manufacturer's guidelines and their (Ceaning and Disinfecting Blood Sugar Monitoring Device, (R2, R27, R28, R29, R30, R31, and 32). CRYSTAL LAKE, IL 60014	NAME OF P	ROVIDER OR SUPPLIER						
Preferst TAG REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOLD BE CROSS-REFRENCED TO THE APPROPRIATE COMMENTION DATE F 441 Continued From page 31 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infection. F 441 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection the facility must isolate the resident. F 441 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with resident ortact for which hands after each direct resident contact for which hands after each direct estilent contact for which hands washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: guidelines and their Cleaning and Disinfecting Blood Sugar Monitoring Devices Policy and Procedures, for seven resident, utilizing the same blood sugar monitoring devices, (R2, R27, R28, R29, R30, R31, and 32). F 441	CRYSTA	L PINES REHAB & HO	cc					
 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must prohibit employees with a acommunicable disease or infected skin lesions from direct contact will resident the disease. (3) The facility must propribit exployees with a arrespont linens so as to prevent the spread of infection. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow manufacturer's guidelines and their Cleaning and Disinfecting Blood Sugar Monitoring Devices Policy and Procedures, for seven residents, utilizing the same blood sugar monitoring device, (R2, R27, R28, R29, R30, R31, and 32). 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
	F 441	 (2) Decides what prishould be applied to (3) Maintains a recording actions related to infinite (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will tr (3) The facility must hands after each di hand washing is incompositional practice (c) Linens Personnel must hand transport linens so a infection. This REQUIREMENT by: Based on observation review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures, for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar review the facility faguidelines and their Blood Sugar Monitor Procedures for several same blood sugar for several same blood sugar for several same blood sugar facility faguidelines and their Blood Sugar Monitor Proce	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective iffections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their frect resident contact for which dicated by accepted ce. ndle, store, process and as to prevent the spread of NT is not met as evidenced tion, interview, and record ailed to follow manufacturer's r Cleaning and Disinfecting pring Devices Policy and ven residents, utilizing the monitoring device, (R2, R27,	F	441			

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145257	B. WI	NG _		08/2;	3/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC		-	35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	The August 2010, (device), Cleaning/D (Blood sugar monitic cleaned/disinfected (Centers for Diseas guidelines, to prevent transmission of blood Procedure: Cleanin To disinfect your m wipe down using a Alcohol is no longed disinfecting of meter completed between gloves to avoid transpathogens." Blood sugar monitor 41, "Caring for your Monitor, Healthcare cleaning solutions i 70%alcohol, or 10% On 8-16-2011 at 11 Nurse) checked R3 sugar monitoring de antimicrobial alcoho disinfect/clean the b E4, (RN) on 8-16-2 think the (Name Brawinges) are what we (blood sugar monitor it. There is one (blood for each wing of the on that wing. We d (blood sugar monitor)	Blood sugar monitoring Disinfecting Policy is, "Policy: oring devices) will be I in accordance with the CDC, se Control) recommended ent the spread and od borne pathogens. Ing and disinfecting guidelines: onitor, clean the monitor and solution of 10% bleach. r recommended for ers. Disinfecting must be n each resident use, wearing hsmission of blood borne oring device, Chapter 8, page r monitor, Cleaning Your e professionals; acceptable nclude 10% bleach, % ammonia." 1:14am., E4, (RN/Registered 82's blood sugar with the blood evice. E4, then used an ol gel hand wipe to blood sugar monitoring device. 011 at 11:35am. stated, "I and, antimicrobial alcohol gel 've been using to clean the oring devices). I've been using ood sugar monitoring device) e facility, for residents residing to not have individual resident	F	441			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145257	B. WI	NG _		08/23/2011		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CRYSTA	L PINES REHAB & HO	cc			35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	"Alcohol 65%."	ed on the container, are,	F	441				
	Nursing) stated, "W (blood sugar monitor provided the contain the active ingredien 6500 parts per million Manufacturer recom	:40am., E2, (DON/Director of re use (Name Brand) to clean oring devices)." E2 then ner. The container identified ts as, "1:10 parts bleach, and on sodium hypochlorite." (As nmended for g the blood sugar monitoring						
	8-16-2011 at 11:55 full time. There are R28, R29, R30, R3 the (Blood sugar m used, and cleaned	nt Director of Nursing) on am., stated, "E4, (RN) works seven residents, (R2, R27, 1, and R32), that would use onitoring device) that (E4/RN) with the hand gel. All seven blood sugar checked."						
F9999	a 3-29-2011 staffing (blood sugar monito		F9	999				
	LICENSURE VIOL	ATIONS						
	300.610a) 300.1210d)5) 300.3240a)							
	Section 300.610 Re	esident Care Policies						
		have written policies and ing all services provided by						

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145257	B. WI	NG _		08/2;	3/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	the facility which sh Resident Care Polic least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th written, signed and meeting. Section 300.1210 (C Nursing and Person d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week 5) A regular program pressure sores, hea breakdown shall be seven-day-a-week enters the facility w develop pressure s clinical condition de sores were unavoid pressure sores sha services to promote and prevent new pr Section 300.3240 A a) An owner, licens agent of a facility st resident.	hall be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and hursing and other services in bolicies shall be in compliance rules promulgated thereunder. ies shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a General Requirements for nal Care section (a), general nursing at a minimum, the following ced on a 24-hour, basis: m to prevent and treat at rashes or other skin e practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's emonstrates that the pressure dable. A resident having ull receive treatment and e healing, prevent infection, ressure sores from developing.	F9	999			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257 NAME OF PROVIDER OR SUPPLIER CRYSTAL PINES REHAB & HCC			(X2) M A. BUI B. WI	NG STR 33	PLE CONSTRUCTION G REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014	FORM OMB NO. (X3) DATE SL COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Based on interview failed/neglected to a facility's policy and Prevention" in the fa 1. Assessment; - A risk assessment (B identify residents w development of pre assessment will be weekly x 4 weeks, o significant change i noted. 2. Planning: - An in be developed to me It will include the co support surfaces, n mobility, continence clinical condition of factors as they app 3. Implementation: prevention of press individualized to me resident. Interventi assessment of risk resident. 4. Evaluation and F Care Management program componer effectiveness of the facility systems. Fin will be reviewed wit Based on evaluatio and further changes plan of care will be This is for 5 (R4, R4 residents sampled	v and record review the facility follow and implement the procedure for "Pressure Ulcer ollowing areas; A standardized pressure ulcer traden Scale) will be used to ho are at risk for the essure ulcers. This completed upon admission, quarterly and when a in the resident's condition is ndividual plan of prevention will eet the needs of the resident. onsideration of mechanical nutrition, hydration, positioning, e, skin condition and overall the resident as well as the risk ly to each individual. - Interventions for the set the specific needs of the ions will consider the and skin condition of the Reassessment: - The facility's System committee will review	F9	9999			

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145257	B. WI	NG _		08/2:	3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa R26) in the supplen	-	F9	999			
	and worsening of a	ributed to the development voidable facility acquired arious stages for these 8					
	Findings include;						
	Conditions of Resid Integrity noted that residents with press	lity's "Resident Census and dents" under section "D" Skin the facility reported 13 sure sores and only 2 of these sure sores on admission.					
	administrator and E stated that they are regarding pressure facility. E1 stated the reasons why this of 2011 the facility cer and that the facility cer pressure sore prevent have enough staff. stated that after loo believe that staffing the facility experien utilized the back-up primary goal during making sure the res stated that perhaps overlooked at this til	8/16/11 at 2:30 PM with E1, the E2, the director of nursing, they aware of the problem sores recently acquired in the hat they are looking at the ccurred. E1 stated that in July nsus went from 90 to over 100 had to hire more staff to meet esidents. E1 stated that the as it should be regarding ention because they did not On 8/17/11 at 10:15 AM E1 oking at the staffing, they now y was sufficient. E1 stated that he these power outages that the these power outages was sidents were hydrated. E1 a some preventive care was ime. 8/22/11 at 9:30 AM with Z1, the					
		$3/22/11$ at 9:30 AM with $\angle 1$, the e states that he was aware of					

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257 CC	(X2) M A. BUI B. WI	NG STR 33	PLE CONSTRUCTION G REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014	FORM OMB NO. (X3) DATE SL COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	the facilities acquire quarterly quality ass that he was probab numbers of acquire not recall how many that he believes in t pressure sore preve checks, frequent re care. Z1 states tha vigilant in these pre that there was a bre but he cannot say v occurred. Z1 states recommending inte with the plan of rem jeopardy situation. 1. On 8/16/11 at 10 for her dressing cha nurse, removed R5 wound is a Stage 3 centimeter (cm) by pressure sore has a approximately 25% confirms a worsenin The record of R5, at to the facility on 8/1 morbidities) includin Disease, Hypertens R5' s record contai order dated 7/18/1 coccyx with sterile r AG and a 4 by 4 Ex needed until resolve " Braden " pressure that states she score	age 37 ed pressure sores in the surance meetings. Z1 states ly informed of the increasing ed pressures sore but he does y the facility has. Z1 states the general philosophy of ention that includes skin positioning and incontinence it the facility needs to be eventive measures. Z1 states eakdown in these processes where the breakdown is that he was not involved in reventions but that he did agree noval regarding the immediate 0:10 AM R5 was in bed waiting ange. E6, the wound care ' s coccyx dressing. R5 ' s pressure ulcer measuring 2.1 1.3cm by .2cm depth. The a thin center yellow slough . These measurements ing of the pressure sore. a 78 year old female admitted 5/09 with diagnoses (co ing Diabetes, Coronary Artery sion and Anxiety was reviewed. ins a physician ' s treatment 1 that states. " Cleanse normal saline apply Maxorb cuderm every 3 days and as ed. " R5 ' s record contains a e sore scale dated 6/13/11 red a 15 which is considered " immum data set dated 5/17/11	F9!	999			

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145257 CC	(X2) M A. BUI B. WI	LDINO	IPLE CONSTRUCTION IG REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014	FORM OMB NO. (X3) DATE SU COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	states that she nee transfer, assistance uses a wheelchair incontinent of bowe Pressure Ulcer Ass 7/18/11 that states coccyx pressure so measured .52 cm b Pressure Ulcer Ass that the wound is no depth which is a wo R5's "Weekly Press dated 8/2/11 states stage 3 measuring 50% necrotic tissue worsening of the pr R5's "Weekly Press sheets show a decl pressure sore every sheet do not show a the onset of the pre R5's record lacks a to prevent and treat In an interview with she states that som care clinic and som physician's are ope and some are not. remember which re will use a wound cli aware that the wou previously. 2. On 8/16/11 at 10 waiting for her heel has an unstageable	ds extensive assistance to e to position herself in bed, and for ambulation and is el and bladder. R5's "Weekly sessment" sheet dated this is the date that a stage 2 ore was identified and by .51cm. R5's "Weekly sessment" dated 7/26/11 states ow 1.5cm by 1.5cm by .1 orsening of the pressure sore. sure Ulcer Assessment" sheet that her pressure sore is a 1.5cm by .8cm by .2cm with e, this is a significant essure sore. sure Ulcer Assessment" ine or worsening in the y week. The physician's order a change in treatment since essure sore on 7/18/11. comprehensive plan of care	F9	999			

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CENTER		AND HUMAN SERVICES	(X2) N	IULTI	IPLE CONSTRUCTION	FORM	02/22/2012 APPROVED 0938-0391 JRVEY
		IDENTIFICATION NUMBER:	(, <u>E</u>) (COMPLE	
		145257	B. WI	NG _		08/23	3/2011
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL PINES REHAB & HCC					35 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	periphery of the wo eschar center (75% This is a worsening injury" that was doo The record of R14, admitted to the faci (co morbilities) inclu Hypertension, Wea was reviewed. R14 Scale for Predicting 7/11/11 that states risk" on this scale. "Weekly Pressure U 8/5/11 that states a was found and mea depth is stated as " a physician's order states "Cleanse left saline. Apply skin p optifoam and wrap contains a Minimun 6/20/11 that states bed mobility, transfe R14's MDS states t ambulation and she bladder. In an interview with stated that she doe developed her pres assessments states development of pre 3. On 8/16/11 at 10 admitted to the hos pressure sores. E2 presented a history	und. R14's wound has a black b) with surrounding red tissue. c) of the "suspected deep tissue cumented on 8/9/11. an 87 year old female lity on 6/20/11 with diagnoses uding Pelvic Fracture, kness and Difficulty in walking, d's record contains a "Braden g Pressure Sore Risk" dated she scored a 22 which is "mild R14's record contains a Jlcer Assessment' dated suspected deep tissue injury asured 5.2cm by 5.9cm and blister". R14's record contains for treatment dated 8/8/11 that t medial heel with normal orep to intact blister, cover with with kerlix." R14's record n Data Set (MDS) dated she needs assistance with ers dressing and hygrine. that she uses a wheelchair for e continent of bowel and E6,the wound care nurse, she is not know how this resident usure sore and that her is she was at low risk for	F9	999			

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
		145257	B. WI	NG _		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	is here from the nur complaint of right for drainageFamily a had decubitus ulcer increased wound ca month2 unstagea right foot, foul smel present. Also deep right knee and decu consulting surgery for care" The record of R4's female admitted to with diagnoses (co Dementia, Anxiety I disease was review states that she requised, transferring, di MDS also states that of both bowel and to wheelchair for amb a "Braden scale for dated 7/6/11 that st signifies "high risk" record contains "W Assessment" dated is when a stage 3 mi dentified and meas with 60% necrotic ti "Weekly Pressure U 8/6/11 that states a pressure ulcer was by .2cm depth. R4'	rsing home with chief bot pain and right foot also noted that the patient also rs for some time but noted are needs for the past able ulcers on the patient's ling with necrotic tissue to tissue injury in the medial ubitus on the right hipWill be for wound debridement and record contains an 84 year old the facility in June of 2010 morbidity) including Diabetes, Hypertension and Joint ved. R4's MDS dated 5/26/11 uires assistance with turning in ressing and bathing. R4's at she is frequently incontinent bladder and that she uses a ulation. E4's record contains predicting pressure sore risk" tates a score of 10 that for pressure sores. R4's eekly Pressure Ulcer 16/16/11 that states this date right hip pressure ulcer was sured 3cm by 1.8cm by .2cm issue. R4's record contains a Ulcer Assessment" dated a stage 2 left medial knee noted measuring 3cm by 2cm 's record contains a "Weekly ated 8/9/11 that states the left ure sore is now a stage 3 with	F9	999			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145257	B. WIN	G		08/2:	3/2011
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			85 NORTH ILLINOIS AVENUE RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	 4. On 8/16/11 at 1 waiting for her dress the right buttock wo depth and a Stage was bleeding slight E6 stated that she developed this press The record of R25 at to he facility with dia including Urinary Ir Hypertension was r contains a "Braden Sores" that state sh which is considered contains a "Weekly Assessment" dated acquired a left buttor measuring .5cm by record contains an she required extens toilet and some ass dressing. This MDS wheelchair for amb incontinent of uri ne of bowel. 5. On 8/16/11 at 10 for her dressing cha hip Stage 2 pressur her thoracic spine S by .7cm by .1 cm do not know why this r pressure sores. The record of R6 at to the facility with dia to the fac	1:00 AM R25 was in bed sing change. E6 measured bund at .3cm by .2cm by .1 cm 2 pressure ulcer. The wound ly. does not know why R25 ssure ulcer. a 94 year old female admitted agnoses (co morbidities) ncontinence, Depression and reviewed. R25's record Scale for Predicting Pressure he scored an 11 on 7/24/11 d "High Risk" R25's record	F99	999			

		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		、 <i>′</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
		145257	B. WI	NG _		08/2;	3/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	CC			335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Cerebral Vascular / Weakness was rev "Weekly Pressure L 6/4/11 that states s Stage 2 pressure se by .1cm. R6's reco Pressure Ulcer Ass states she acquired measuring 1.3cm b an MDS dated 6/5/ extensive assistant hygiene. This MDS incontinent of bowe 6. On 8/16/11 at 1 waiting for her dres her left buttock Stag .5cm by .1 cm dept slightly. E6 stated t R24 developed a pu The record of R24 a admitted to the faci morbidities) includir Fibrillation, Ischemi Dementia was revie "Braden Scale for F dated 8/5/11 that states h pressure ulcer mea cm depth. R24;s re 7/5/11 that states s assistance to transf MDS also states that with bed mobility, e	Accident and Muscle iewed. R6's record contains a Ulcer Assessment" dated he acquired a thoracic spine ore measuring .3cm by .3cm ord contains a "Weekly sessment" dated/12/11 that d a right hip pressure sore by .2cm. R6's record contains 11 that states she required ce with transfers, dressing and S also states that she is el and bladder. 1:50 AM R24 was in bed ssing change. E6 measured ge 2 pressure sore 1cm by h. This wound was bleeding that she does not know why	F9	999			

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		```	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145257		B. WI	NG		08/2:	3/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 35 NORTH ILLINOIS AVENUE		
CRYSTA	L PINES REHAB & H	CC		_	RYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa incontinent of bowe	-	F99	999			
	another dressing ch purposes. On 8/18/	tated that R26 refused to have nange for observation (11 E1, the administrator s being admitted to the piratory problems.					
	admitted to the faci Diabetes (co morbin record contains a "F Pressure Sore Risk 15 which is conside contains a "Weekly dated 8/6/11 that st inner buttock press cm by .01 cm depth MDS dated 8/10/11 extensive assistance hygiene. This MDS assistance with bec	an 82 year old female lity with diagnosis including dities) was reviewed. R26's Braden Scale for Predicting (" dated 8/6/11 that scores her ered "Mild Risk". R26's record Pressure Ulcer Assessment" tates she developed a right ure sore measuring .8cm by 1 n. R26's record contains an that states she requires ce for transfers, dressing and S also states that she requires d mobility. This MDS also ncontinent of bowel and					
	condition was chec (CNA-certified nurs	t at 11:45 A.M., R8's skin ked in the presence of E10 e assistant). R8 has a stage II her right upper spine.					
	dated 8/8/2011 sho measures 1.5 x 3x record,this pressure	Monthly Skin Assessment" wed that R8's pressure ulcer 0.1 cm. According to R8's e ulcer was first identified and 8 at the facility on 8/8/2011.					
		are plan indicated that R8 at risk for pressure ulcers					

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		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
	145257		B. WI	√G _		08/23/2011	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTA	L PINES REHAB & H	сс		-	CRYSTAL LAKE, IL 60014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	related to declining bladder and bowel, vascular accident), sensation in feet. T interventions to add includes for R8 to b redistributing mattre cushion. R8 was observed of A.M., 8/16/2011 at R8 was sitting in a observation showed on the reclining whe redistribution chair P.M., E13 (CNA) st R8 's reclining whe On 8/16/2011 at 3: meeting, the conce redistribution cushid was discussed with (Director of Nursing On 8/17/2011 at 12 the main dining roo reclining chair. R8 v redistribution cushid Nursing) was present	condition, incontinence of history of CVA(cerebral right sided weakness and loss the care plan indicates that dress R8's pressure ulcer be placed on a pressure ess in bed and wheelchair on 8/15/2011 at around 10:30 12:30 P.M., and 2:30 P.M. reclining wheelchair. Further d that R8 was sitting directly eelchair without a pressure cushion. On 8/16/2011 at 2:30 tated that she never had seen elchair cushion.	F9	999			

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